Stark Opening Statement From Hearing On Medicare Advantage Private Fee-For-Service Plans

Wednesday, 16 May 2007

Representative Pete Stark (CA-13), Chairman of the Ways and Means Health Subcommittee, delivered the following opening remarks at today's hearing on Medicare payments to hospitals and post-acute providers.

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STARK OPENING STATEMENT AND CMA LETTER FROM HEARING ON MEDICARE

ADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS

WASHINGTON, D.C. -- Representative Pete Stark (CA-13), Chairman of the Ways and Means Health Subcommittee, delivered the following opening remarks at today's hearing on Medicare Advantage Private Fee-For-Service Plans (PFFS).

Representative Stark also submitted the following letter from the California Medical Association (CMA) into the Hearing Record. The CMA has called on Congress to eliminate PFFS from the Medicare Advantage program. The CMA letter is available at here.

“Today’s hearing continues oversight on the Medicare Advantage program. Shadowboxing with the Administration’s message machine is getting tiresome, but at least Ms. Block will repeat today what she apparently told press yesterday. Ever the optimist, I hope today’s hearing will

contribute to a rational conversation about these issues. To that end, I am going to suggest an unconventional approach. Many of the witnesses on our second panel have said they are having trouble getting the Administration to pay attention to them. Thus, I would like to flip our panels so that Ms. Block and others from CMS are able to listen to the suggestions from outside experts.

“Private Fee-For-Service plans are unique among Medicare Advantage (MA) offerings, and are the focus of today’s hearing. According to MedPAC, these plans are paid on average 119% of fee-for-service rates – rising to 150% or more in some areas. Since business follows the money, it’s no surprise that enrollment is skyrocketing. The rate of growth from 2002-2007 was an astounding 5600 percent. Even so only 1.3 million people – about three percent of all beneficiaries – are in these plans now. Given that half of the projected MA growth is in this option, we need to immediately evaluate its value before it gets unmanageable.

“Unlike most of the MA options, these plans do not typically have a network of providers. They are marketed as operating the same as traditional Medicare, but with lower cost-sharing and perhaps other additional benefits. Yet, reality often fails to match the sales pitch.

“These plans may offer flat co-payments for physician visits, but physician co-payments of even $15-20 are often higher than the corresponding 20 percent co-insurance in traditional Medicare. In addition, these plans tend to charge higher cost-sharing for certain Medicare-covered services like skilled nursing facilities, home health, and durable medical equipment. My guess is that this is NOT coincidental. If you don’t want sick people, you charge more for the services that they are looking for.

“While these plans promote the ability to see any provider, they neglect to mention that providers are not required to accept the plan’s payment terms, and that providers can decide on a per-visit basis whether to participate. Beneficiaries who have signed up for these plans are just beginning to confront this confusing situation. I’d like to ask unanimous consent to submit for the Record a letter from the California Medical Association. They’ve become so disgruntled with the PFFS plans that they’re asking us to eliminate this particular option.

“We’ll also hear today about the difficulty faced by insurance commissioners attempting to regulate the sales practices of these products. High profit margins for this plan type have provided incentives for plan sponsors to offer huge commissions to sell these plans. If you think used car salesmen are bad, they have nothing on some of the hucksters selling PFFS plans. We’ll hear today about outright fraud, and both intentional and unintentional misrepresentations about what these plans mean for individual beneficiaries. Yet the 2003 Medicare Modernization Act prohibited state oversight of these products, and this Administration has consistently dragged its feet both on requiring better behavior and enforcing the rules that are in effect. Even worse, they’ve interfered at times with the limited ability retained by the states with respect to oversight on agents and brokers. I hope this hearing will lay the groundwork for positive change.

“PFFS plans are exempt from MA quality and plan adequacy requirements so we cannot determine what, if any, value these plans provide. I look forward to discussing this huge loophole today.

“We’ll also hear from one actual plan today, but their situation is unique. Even so, Mr. Camp’s local plan deserves some credit for their willingness to appear today. I gather you were left with no other

choices – other prominent plans “declined” the offer, while still others were not invited because of their bad behavior. This speaks volumes to me about this product and its future.

“This Subcommittee has a responsibility to provide effective oversight, and assure that beneficiaries and taxpayers are getting both value and quality for their investment. PFFS plans appear to provide far better value to their shareholders and their companies’ bottom lines than they do to Medicare.

“As I’ve said all year, as we look to improve and protect Medicare, all provider payments must be reviewed and are subject to change. Given what we know about PFFS at this time, they’re at the top of my list. I look forward to today’s testimony and I yield to Mr. Camp for any opening statement he’d like to make.”

May 20, 2007

The Honorable Pete Stark
Chairman, Health Subcommittee
Ways and Means Committee
U.S. House of Representatives
1135 Longworth HOB
Washington, D.C. 20515

RE: CMA Supports Elimination of the Private Fee-For-Service Plans (PFFS)

Dear Chairman Stark:

On behalf of the California Medical Association, I am writing to urge you to eliminate the Medicare Advantage Private Fee-For-Service Plans

(PFFS) from the Medicare Advantage program. The CMA has studied these plans carefully and we have concluded that the higher payment rates from Medicare (119% of Medicare fee-for-service rates on average), the lack of value to the program in terms of efficiency and quality, the inadequate physician networks, the disincentive to negotiate competitive contract terms with physicians due to the “deeming” authority and the well documented marketing abuses, have made the PFFS plans unwarranted profit-centers for the insurance industry at the expense of patients, physicians and the taxpayers.

Last fall, the CMA received hundreds of phone calls from physicians complaining that their long-time Medicare patients had enrolled in PFFS plans with which they were not contracted. Every physician we spoke to said that their patients were erroneously told by the insurance broker that they could continue to be treated by their current physician even though their physician was not contracting with the plan. This caused the unnecessary disruption of many existing physician-patient relationships.

Many physicians who did not know that their patients had enrolled in a PFFS plan continued to treat their patients and were therefore, “deemed contracted” with the plan. Under the law, PFFS plans may unfairly “deem” physicians to be contracted with the plan when a physician treats a patient who has enrolled in a PFFS plan. Physicians who do not contract but remain “deemed” are paid according to the Medicare fee-for-service fee schedule. However, these physicians must adhere to the PFFS plans’ terms and conditions which are subject to change at any time. These terms and conditions are not readily available to physicians and not consistent Medicare payment rules. CMA has repeatedly asked CMS to require PFFS plans to post their payment rules on a single website where physicians can readily obtain the information.

Unfortunately, patients who see “deemed” physicians must pay higher copayments. However, if a physician agrees to sign a contract with a PFFS plan, once the plan establishes an “adequate” network, they may reduce the physician’s payment rates below the Medicare fee-for-service fee schedule. But the patient’s copayments may be reduced. Physicians have found themselves in an untenable situation.

The problems are rapidly compounding because PFFS plan enrollment is growing astronomically in California consistent with the national average of 284%. Moreover, the PFFS plans are paid on average 119% and up to150% of the Medicare physician fee-for-service fee schedule. Thus, their rates are 20-50% higher than physician rates. However, these plans are not required to have adequate physician networks or meet any quality standards. CMA does not believe that many of the PFFS plans operating in California have adequate physician networks to serve their enrollees. Further, we question whether PFFS plans have appropriate incentives to establish appropriate networks. Further, there is no evidence that they are providing a valued service in terms of coordinating care or in providing efficiency. MedPAC has shown that the PFFS plans are the most inefficient plans operating within the Medicare Advantage program. MedPAC has reported that these plans are “…expanding their enrollment and providing extra benefits with taxpayer dollars in an inefficient manner.”

While CMA supports Medicare Advantage health plan options for the Medicare program, we do not support the continuation of PFFS plans for all of the reasons mentioned above. They are unwarranted profit-centers that are siphoning-off valuable resources from the Medicare program. They are not providing value to patients and are allowed to hold physicians to untenable terms. We believe they will ultimately cause access problems in the Medicare program. We urge Congress to act to eliminate the PFFS plans before thousands of

additional California seniors enroll in these plans.

Mr. Chairman, thank you for the opportunity to comment on the PFFS plans. I send you my best wishes and hope to see you in the District again soon.

Sincerely,

Anmol S. Mahal, MD

President